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_____

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*EMAIL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Request Date: _____

Patient Name: _____DOB: _____

Contact Phone No. _____

- **PLEASE CHECK ONE OF THE FOLLOWING REQUESTS**:

☐ I authorize Pediatric Neurologists of Palm Beach to **RELEASE** my medical records to (circle):

Provider/Facility/Guardian_____

Address _____

City, State, Zip _____

EMAIL ADDRESS_____

FAX THIS RELEASE TO: 561-795-5004 OR EMAIL: STAFF@PEDINEUROLOGISTS.COM

YOU ARE REQUESTING TO RECEIVE YOUR RECORDS VIA EMAIL. NOTE THIS IS NOT AN ENCRYPTED EMAIL AND MAY NOT BE SECURE. YOU ARE ACCEPTING THESE RISKS. SECURE TRANSFER OF MEDICAL RECORDS INCLUDE FAX AND MAIL. YOU CHOOSE NOT TO ELECT THOSE OPTIONS THAT WE OFFER.

REQUEST FOR: Transfer Care _____Other- specify_____

TYPE OF RECORDS REQUESTED: Entire Records_____Notes_____

Diagnosis Letter (school)_____ Imaging _____ EEG/VEEG_____

Labs_____ *Other (specify)_____

I am authorizing release of all my records. If the person or facility receiving this information is not a healthcare or medical provider covered by privacy regulations, the information stated above could be re-disclosed (ie: school etc). The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Your provider can charge you a fee for the requested records. *Charges for personal use $1.00 per page, up to 25 pages then $0.25 every page after that. There will be NO Charge to send your records to another provider.*

Patient or Guardian Signature _____Date: _____

*This release expires 30 days from date of signature and can be revoked with notification in writing.